Providence Pediatric Neurology
9427 SW Barnes Rd., Suite 395
Portland, OR 97225
Phn (503) 216-6050 Fax (971) 282-0101

New Patient Intake Form

Appointment Date: _____

Foreign Language Interpreter □ No □ Yes If yes, which language? _____

Patient Name_____ DOB: _____

Patient's preferred name to be called: _____

Referring Doctor/Primary Doctor: _____

For Clinic Use

Height: _____ cm

Weight: _____ kg

BP: _____ /_____ R / L

Pulse: _____

What brings you in to see the Pediatric Neurology doctor today?

_____

_____

Past Medical History:

1. Prior neurologic evaluations? □ No □ Yes _____
2. Prior genetic consultations and/or genetic testing? □ No □ Yes _____
3. Other specialists seen? Who, when, why? _____
4. Pregnancy and Birth History
    a. Birth Weight: _____ and Length: _____
    b. Any illness during Mother's pregnancy? □ No □ Yes _____
    c. Full term, Early, or Late Arrival? _____ How early or late, if applicable? _____
    d. Stayed with Mother or sent to NICU? _____ If NICU, how long and why? _____
    e. Did baby pass newborn hearing exam? □ No □ Yes _____
    f. Other? _____
5. Problems during 1st year of life? □ No □ Yes _____
6. Hospitalizations: □ No □ Yes _____
7. Surgeries (Ear tubes, tonsils, etc.): □ No □ Yes _____
8. Chronic Illnesses (asthma, diabetes, etc.): □ No □ Yes _____
9. ADHD/ADD or any learning disabilities? Any grades repeated? □ No □ Yes _____
10. Is patient in special education? IEP/504 Plan? □ No □ Yes _____
11. Any concerns about development? (Approximations are fine) □ No □ Yes _____
    a. Started sitting? _____ Walking? _____
    b. First tooth? _____
    c. First word? _____ Talk in sentences? _____
    d. Toilet train? _____

(COMPLETE BACK OF FORM PLEASE)

12. Medications, supplements, vitamins, herbs (please include dose and how many times a day):

    _____

    _____

    _____

13. Allergies: □ No □ Yes Medication or seasonal? _____
14. Immunizations Up to Date: □ No □ Yes _____

A. Family History:

Diabetes	□ No □ Yes	Who?
Hypertension	□ No □ Yes	Who?
Migraines	□ No □ Yes	Who?
Headaches	□ No □ Yes	Who?
Seizures	□ No □ Yes	Who?
Learning Disabilities	□ No □ Yes	Who?
Learning Disorders	□ No □ Yes	Who?
Developmental Disabilities	□ No □ Yes	Who?
Birth Defects	□ No □ Yes	Who?
Other neurological or genetic issues	□ No □ Yes	Who?

B. Social History:

1. Who lives at home with the patient? _____
2. Parents' occupation/job/employer? Mother: _____ Father: _____
3. Parents are married/single/divorced/separated? (circle please)
4. Grade in school: _____
    a. Does the patient like school? □ Yes □ No _____
    b. Approximate grades on report card? _____
    c. Favorite subject? _____
5. Hobbies outside of school? _____
6. Sports? □ No □ Yes _____
7. Pets? □ No □ Yes _____

Anything else you would like for your doctor to know about you? _____

Phone number for provider to reach you: _____

Preferred Pharmacy: Name, Street, City, State _____

REVIEW OF SYSTEMS / MEDICAL -- Providence Pediatric Neurology

Please indicate below. Is the patient CURRENTLY experiencing any of these symptoms?

General, Constitutional

Good general health lately……	no	yes
Recent weight change……	no	yes
Fever……	no	yes
Fatigue……..	no	yes

Eyes and Vision

Eye disease or injury……	no	yes
Wear glasses or contact lenses……	no	yes
Blurred, double-vision, flashing lights……	no	yes

Last eye examination: _____

Ears, Nose, Throat

Hearing loss……	no	yes
Ringing in the ears……	no	yes
Earaches or drainage……	no	yes
Sinus problems……	no	yes
Swollen glands in neck……..	no	yes

Heart and Cardiovascular

Heart trouble……	no	yes
High blood pressure……..	no	yes
Heart murmur……	no	yes

Respiratory

Frequent coughing……	no	yes
Shortness of breath……	no	yes
Asthma or wheezing……	no	yes

Gastrointestinal

Loss of appetite……	no	yes
Bowel incontinence……..	no	yes
Nausea or vomiting……	no	yes
Feeding difficulty……	no	yes

Genitourinary

Frequent urination……	no	yes

Skin

Rash or itching……	no	yes
Change in skin color……..	no	yes
Lumps……	no	yes

Musculoskeletal

Joint pain……..	no	yes
Weakness of muscles/joints……	no	yes
Muscle pain or cramps……..	no	yes
Back pain……	no	yes
Cold extremities……	no	yes
Difficulty in walking……..	no	yes
Limitation of motion or activity……	no	yes

Neurological

Frequent or recurrent headaches….	no	yes
Light-headed or dizzy……..….	no	yes
Convulsions or seizures……..	no	yes
Numbness or tingling sensations…	no	yes
Tremors……	no	yes
Paralysis……	no	yes
Stroke……	no	yes
Head injury……	no	yes
Involuntary movements……	no	yes

Psychiatric

Memory loss or confusion……	no	yes
Nervousness……..	no	yes
Depression……..	no	yes
Sleep problems……..	no	yes

Endocrine

Glandular or hormone problem……	no	yes
Thyroid disease……	no	yes

Hematological/Lymphatic

Easily bruise or bleed……	no	yes
Anemia……	no	yes
Swollen Glands……	no	yes

Diagnostic Imaging Performed

MRI……	no	yes
CT……	no	yes
EEG……	no	yes
Ultrasound……	no	yes
Labs in the last 3 months……	no	yes

If you answered yes to any of the above questions, please explain: